The Community

American Health
Information Community

September 12, 2006
8:30 a.m. - 12:30 p.m.

U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Room 800
Washington, DC 20201

Confidentiality, Privacy, and Security Workgroup - Charges

Broad Charge for the Workgroup:

Make recommendations to the Community regarding the protection of personal health information in order to secure trust, and support appropriate interoperable electronic health information exchange.

Specific Charge for the Workgroup:

Make actionable confidentiality, privacy, and security recommendations to the Community on specific policies that best balance the needs between appropriate information protection and access to support and accelerate the implementation of the consumer empowerment, chronic care, and electronic health record related breakthroughs.

Confidentiality, Privacy, and Security Workgroup – Members

Co-Chairs

Paul Feldman	The Health Privacy Project
Kirk Nahra	Wiley Rein & Fielding, LLP

Members

John Houston	National Committee on Vital and Health Statistics
Tony Trenkle	Centers for Medicare and Medicaid Services
C. David McDaniel	Veterans Health Administration
Susan McAndrew	HHS/Office of Civil Rights
Don Detmer	American Medical Informatics Association
Alison Rein	National Consumer League
Deven McGraw	National Partnership for Women and Families
Thomas Wilder	America's Health Insurance Plans
Paul Uhrig	Surescripts
Jill Callahan Dennis	Health Risk Advantage
Flora Terrell Hamilton	Family and Medical Counseling Service
Peter Basch	MedStar e-Health
Steven Davis	Oklahoma Department of Mental Health & Substance Abuse Services
Yvonne Maddox	HHS/NIH/National Institute of Child Health and Human Development

Office of the National Coordinator

Jodi Daniel	Office of Policy and Research

Quality Workgroup - Charges

Broad Charge for the Workgroup:

Make recommendations to the American Health Information Community so that HIT can provide the data needed for the development of quality measures that are useful to patients and others in the health care industry, automate the measurement and reporting of a comprehensive current and future set of quality measures, and accelerate the use of clinical decision support that can improve performance on those quality measures. Also, make recommendations for how performance measures should align with the capabilities and limitations of health IT.

Specific Charge for the Workgroup:

Make recommendations to the American Health Information Community that specify how certified health information technology should capture, aggregate and report data for a core set of ambulatory and inpatient quality measures.

Quality Workgroup - Members

Co-Chairs

Carolyn Clancy	Agency for Healthcare Research and Quality
Rick Stephens	Boeing Corporation

Members

George Isham	Health Partners; Ambulatory Care Quality Alliance
Helen Darling	National Business Group on Health
Nancy Foster	American Hospital Association
Barry Straube	Centers for Medicare and Medicaid Services
Jane Metzger	Rhode Island Hospital
Susan Postal	Hospital Corporation of America
Jonathan Teich	Brigham and Women's Hospital
Janet Corrigan	Board on Health Care Services
Margaret van Amringe	Joint Commission on Accreditation of Healthcare Organizations
Reed V. Tuckson	United Health Foundation
Anne Easton	Office of Personnel Management
Abby Block	Centers for Medicare and Medicaid Services
Margaret O'Kane	National Center for Quality Assurance

Office of the National Coordinator

Kelly Cronin	Office of Programs and Coordination

State-Level Health Information Exchange Initiatives

Linda L. Kloss, MA, RHIA
CEO, American Health Information Management Association (AHIMA)

September 12, 2006

Project Overview

- Selected nine state-level HIE initiatives for study of
  - Governance
  - Financial and operational characteristics
  - Health information exchange policies
  - Short and long-term priorities
- Developed guidance for state-level initiatives
- Hosted a consensus conference to refine guidance
- Prepared a *State Level Health Information Exchange Initiative Development Workbook: A Guide to Key Issues, Options and Strategies*
- Developed a plan to disseminate findings
- Outlined recommendations for follow-on project and policy work

Project Team

- Project Staff
  - Victoria Prescott, Esq General Counsel and Business Development Specialist, Regenstrief Institute, Inc., Indianapolis
  - Kalea Layman
  - AHIMA and FORE staff
- Steering Committee members and other state-level HIE staff
- Technical Advisors
- National Conference of State Legislators
- ONC and AHRQ
- Liaisons to other organizations

Steering Committee

Chair

- Molly J. Coye, MD, MPH, Founder and CEO, **Health Technology Center**, San Francisco, CA

Committee Members

- Laura L. Adams, President and CEO, **Rhode Island Quality Institute**, Providence, RI
- Antoine Agassi, Director and Chair of the **Tennessee eHealth Council**, Nashville, TN
- Ray Campbell, Esq., MPA, CEO, **Massachusetts Health Data Consortium**, Waltham, MA
- Alice Chapin, Project Coordinator, **HealthInfoNet**, Manchester, ME
- Lynn Dierker, RN, Director for Community Initiatives, **Colorado Health Institute**, Denver, CO
- Lori Hack, MBA, Interim CEO, **CalRHIO**, San Francisco, CA
- W. Michael Heekin, Esq., Chair of the **Florida Governor's Health Information Infrastructure Advisory Board**, Atlanta, GA
- Marc Overhage, MD, PhD, FACP, FACMI, CEO, **Indiana Health Information Exchange, Inc**.;Indianapolis, IN
- Jan Root, PhD, Assistant Executive Director, **Utah Health Information Network**, Murray, UT

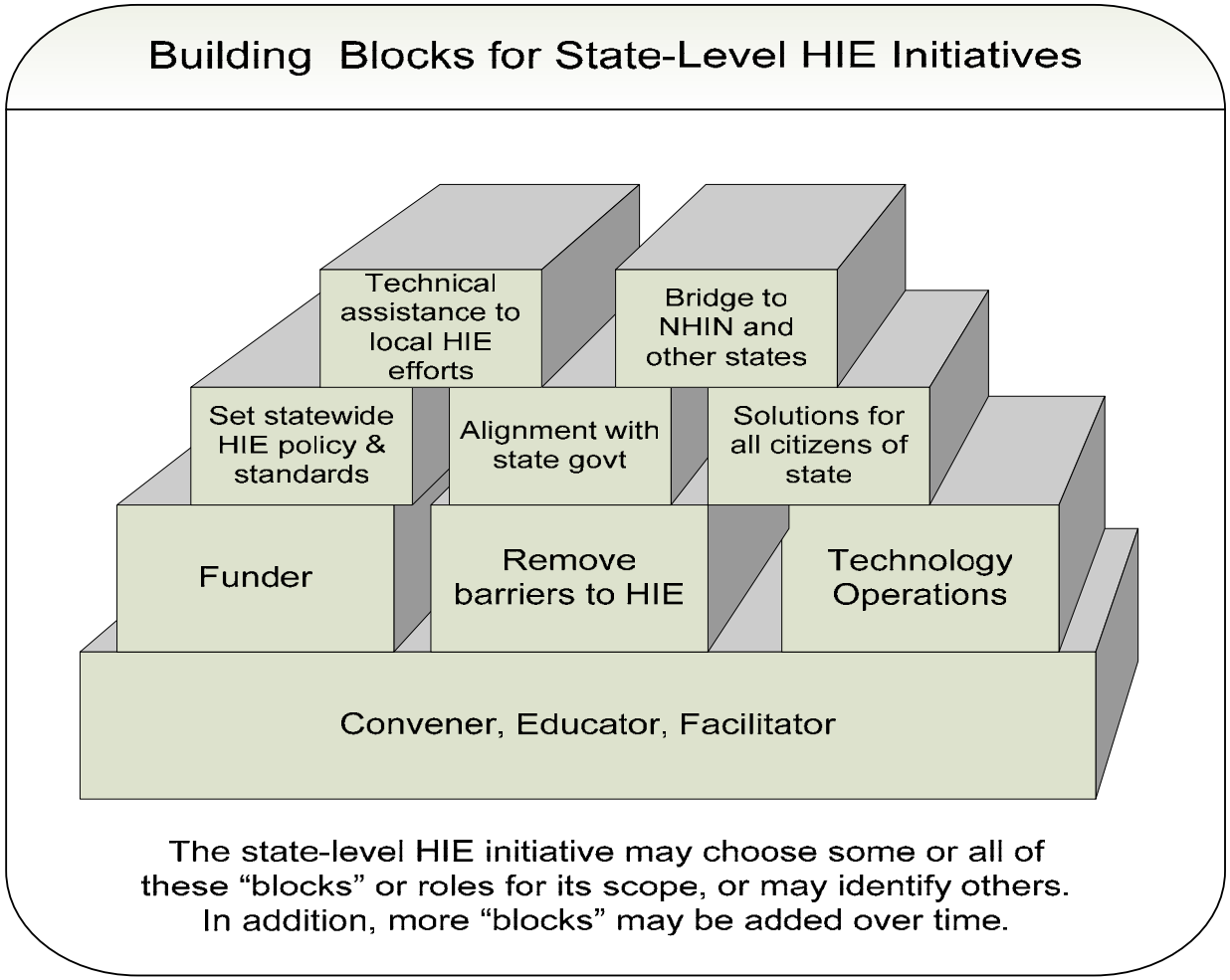
Technical Advisors

- William Bernstein, Esq., Partner, Manatt, Phelps & Phillips
- Bruce Fried, Esq., Partner, Sonnenschein, Nath & Rosenthal LLP
- John Glaser, PhD, Vice President and Chief Information Officer, Partners HealthCare System, Inc.
- Gerry Hinkley, Esq., Partner, Davis Wright Tremaine
- Kala Ladenheim, Program Director, Forum for State Health Policy Leadership, National Conference of State Legislatures
- Stephen T. Parente, PhD, MPH, MS, Principal, HIS Network, LLC, and Assistant Professor, Department of Finance, Carlson School of Management, University of Minnesota
- C. William Schroth, MBA, Consultant for the New York State Department of Health
- Christopher S. Sears, Esq., Partner, Ice Miller LLP, Indianapolis

Key Findings

- Important innovation and learning underway in many states
- There is no single model for state-level HIE initiatives, nor should there be
- States are uniquely positioned to engage stakeholders for coordination of HIE efforts
- States play a critical role in the nationwide health information network and must be more fully engaged in partnering with the federal government in its development
- Even the most experienced, face significant barriers

Critical Roles for State-Level Initiatives



Major Barriers

- Funding for organization-building and to sustainability
- Lack of consensus on the most effective role for state government in HIE
- Minimal participation and support from private payers
- Non-aligned stakeholder interests
- Lack of shared experience about strategies for success and high impact start up projects
- No roadmap for how state-level HIE relates to federal NHIN programs, including how contiguous states should relate to one another

Recommendations

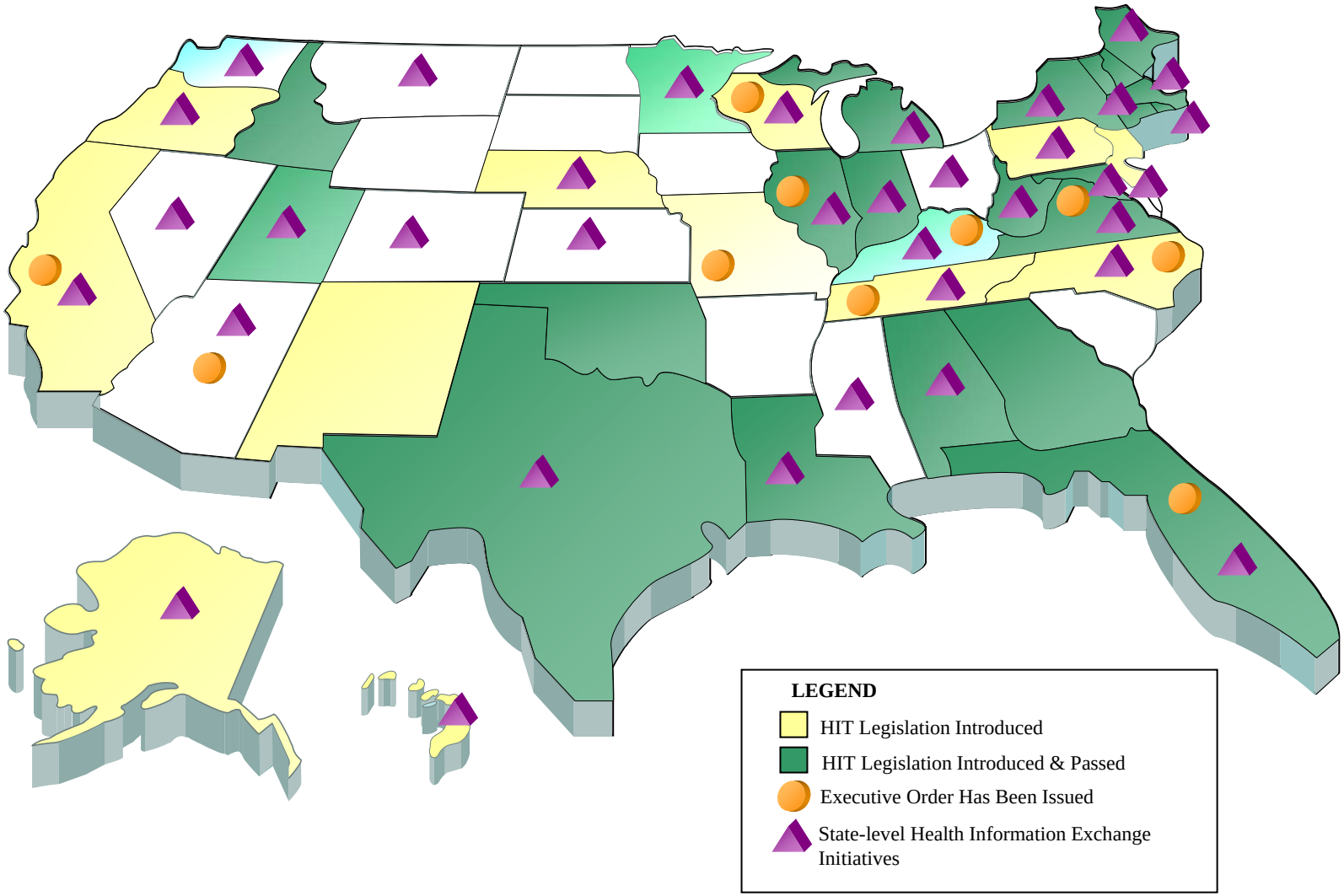
- Mechanisms to promote strategic synergy among states and between state and federal efforts.
  - Coordinating body for active ongoing collaboration
  - Roadmap and explicit linkage of AHIC and ONC vision and project
- Salient financial models for sustainable HIE
- Engage and leverage public and private payers
- Advance understanding of how state policymakers and governmental agencies should be involved
- Vehicles for support and knowledge sharing among state-level HIE initiatives

State-Level Health Information Exchange Initiatives

Kelly Cronin, Director
Programs and Coordination
Office of the National Coordinator
for Health Information Technology

September 12, 2006

State Level HIT Initiatives



What are States Doing?

- 38 states are participating in a state-wide or regional collaborative related to HIT and HIE
- 21 states are convening stakeholders for planning, communication, and coordination
- 16 states are providing staff to plan or manage activities
- 17 states are providing funds to support regional efforts
- What should the federal government do to support this activity?

Next Steps to Support State-Level HIE

Based on Steering Committee recommendations, ONC is funding additional work to:

- Identify barriers with federal solutions
- Recommend HIE cost models that have generated revenue
- Determine the involvement of state Medicaid programs
- Examine the flexibility of state Medicaid programs to facilitate HIE
- Explore how and when to engage CMS and other public payers
- Examine the role of the VA, DoD, and the federal employees health benefit program
- Create explicit links and coordination mechanisms between the work of AHIC and ONC and State-level HIE

Next Steps to Support State-Level HIE

ONC is also supporting the formation of a new state collaborative, mirroring the role of AHIC at the state level to address:

- Long term solutions to ensure privacy and security
- State law practice of medicine barriers to HIE
- Governance models
- Sustainable business models for HIE
- Role of private payers
- Integration of state public health and health care programs

Health Information Exchange in Rhode Island

Laura L. Adams
President and CEO
Rhode Island Quality Institute

September 12, 2006

Rhode Island Environment

- Major Issues
  - Small market – two commercial insurers, uninsured rising
  - Cost pressures on all fronts
  - Digital divides – hospitals, physicians, CHCs, etc.
  - Strong leadership from the Governor
- New Developments
  - Recently passed legislation
    - Health Care Quality and Cost Transparency
    - RHIO Designation and Funding Potential
- What The RI Quality Institute is Trying to Accomplish
  - Achieve significant improvement in health care quality, safety and value
  - Be the “community table” for these issues that include consumers

Health Information Exchange Activities

- Building state-wide HIE in partnership with the State
  - $5M AHRQ contract to RI DOH
  - RIQI as the governance structure
  - HISPC
  - Part of Governor's Health Care Agenda
- Promoting EHR adoption state-wide
  - Creating partnerships to lower the barriers
  - Informing pay-for-performance programs
- Promoting eRx adoption state-wide
  - Goal of 75% of all Rx's sent electronically by end of 2007
- Enabling administrative data exchange
- Promoting standards
- Developing the business case and sustainability plan
- Planning for coordination of PHR efforts

Additional HIE Activities

- Significant market-driven activity
  - Hospitals connecting with their partners
    - EHR vendors
    - Labs, imaging centers
    - Ambulatory care providers
    - Insurers developing web portals
    - Everyone (it seems) developing PHRs
- Budget Article for $20 M Revenue Bond (2006 session)
  - Calls for officially-designated RHIO
  - RHIO would be eligible for financing HIE through state bonding authority
  - State to pay its proportionate share (State employees, Medicaid) if other sectors participate.

Governance and Operation

- Who Makes Decisions and How
  - The RIQI Board (a strong Public/Private partnership with the State)
    - One organization/one vote on the RIQI Board
  - Key issues identified by the Board or Committee of Chairs
  - Workgroups/ad hoc committees that include Board members formed when needed
  - Options and recommendations are brought before the Board in open public forum for vote
  - Consumer Advisory Committee with strong leadership also provides input

State Role

- Governor personally engaged – health care agenda aligned with HIT efforts in state
- Pioneering work with Childhood Immunizations ("KidsNet")
- HHS Secretary, Director of Health, Health Insurance Commissioner providing strong leadership
  - RI DOH applied for and awarded AHRQ SRD contract
  - RIQI eRx initiative led by RI DOH Director
  - RIQI Policy and Legal Committee led by RI DOH Director
  - RIQI Sustainability Committee led by Health Insurance Commissioner
  - $20M revenue bond

Federal Role

- Advance the work of the NHIN prototypes and cost estimates to determine how HIE will be sustainable
- Ensure federal health IT initiatives support state and regional initiatives and, with dialogue, create a more actionable federal agenda
- Assist states in aggregating their market power--employers, Medicaid payers, and regulators should work together
- Answer the question of “who benefits” based on real world experience
- Rapidly advance a national prescription drug history

Health Information Exchange in Massachusetts

Ray Campbell, Executive Director
Massachusetts Health Data Consortium

September 12, 2006

Massachusetts Environment

- 6 Million People, Compact Geography
- Dense Cluster of World-Class Healthcare Institutions
- Sophisticated Technology Economy
- Local Non-Profits Dominate the Provider and Payer Communities
- Established Tradition of HIT Collaboration
- Chapter 58 of the Acts of 2006 – The Health Reform Law

Health Information Exchange Activities

The Massachusetts “Virtual RHIO”

1. Massachusetts Health Data Consortium (the Convener)
2. NEHEN (Administrative HIE)
3. MA-SHARE (Clinical HIE)
4. Massachusetts eHealth Collaborative (the Last Mile)
5. MassPRO (QIO DOQ-IT program)

Governance and Operation

- MHDC has been convening the Massachusetts HIE community for 28 years
- Deeply ingrained culture of collaboration on HIE
- Multiple organizations allows for tailored governance
- Large, inclusive, overlapping Boards of Directors

State Role

- Encouragement, support, and thought leadership
- Participation on every Board of Directors
- Financial support for certain initiatives:
  - MHDC ongoing support ($)
  - MA-SHARE development costs ($$)
- No legislation or executive orders needed to date

Federal Role

- Provide thought leadership
- Use the bully pulpit to drive change and get buy-in
- Remove federal barriers to HIE
- Help align incentives to foster a market for HIE
- Avoid proscriptive mandates – providers and payers need flexibility to adapt to local circumstances
- Be cautious about trying to force a resolution – it will take time and iterative learning before we can reach our ultimate goal

Health Information Exchange in Colorado

Lynn Dierker, RN
Director for Community Initiatives
Colorado Health Institute

September 12, 2006

Colorado Environment

- Colorado
  - Preference for the market over government solutions
  - Diverse geography with changing demographics (30% Latino)
  - A decade of severe state budget constraints
  - Majority small employers
- Health and Health Care
  - Highly competitive health care systems
  - Rising uninsured (17%)
  - Worrisome health statistics (immunization, diabetes, low birth weight)
- On the Horizon
  - Gubernatorial election

Health Information Exchange Activities

- The goal – a federated interoperable system
- Multifaceted technical development efforts
  - AHRQ state/regional demonstration (point of care clinical data exchange)
  - Privacy and security analysis and solutions (HISPC project)
  - Population/public health via InformationLinks
  - Collaboration with NHIN project
- Significant community and sector activity
  - Clinical messaging between care partners
  - Community and provider-based RHIOs
- Concerns about levels of adoption but efforts occurring among individual, small practices, safety net, rural

Emerging State-Level HIE

- CORHIO (Colorado Regional Health Information Organization)
- Now “Virtual”
  - Colorado Health Institute as independent, neutral convener
  - Voluntary coalition emerging over 2 years
  - Consensus on principles, model
  - Engaging HIE leaders/sectors
- Seeking to Put the Stake in the Ground by Year’s End
  - Determining the value proposition and political will
  - Establishing governance (creating a new 501(c)(3))
  - Building a viable economic and model (and resources)
  - Looking to leverage emerging resources in other states, nationally
  - Getting started with state-wide HIE (of some sort!)
- Challenges and Opportunities
  - State engagement and investment
  - Gaining clarity (and consensus) when everything’s moving
  - Leveraging prevailing conditions
  - National momentum

State Role

- Low level participation to date
  - Conversations with Medicaid agency
  - Interest and participation in CORHIO Steering Committee
  - Developing pilots (public health)
  - The governor's support for HISPC participation
  - Legislature awareness and activity (telemedicine and Medicaid, briefing on HIT)
- Likely increase in attention
  - Impending change in administration, legislature
  - Medicaid program /state budget challenges
  - Growing momentum among state policymakers

Federal Role

- Leadership
  - To bring Medicaid and other health plans to the table
  - To increase the synergy among national level initiatives/federal programs
- Communication
  - Send a clear message about the importance of state-level HIE/organizations
- Build more effective working partnerships with states
  - Obtain ongoing input and guidance from states
  - Find creative ways to help states and channel resources at all stages
- Strive to put the federal house in (more) order
  - Expand the timeframes for action and support from the federal level
  - Coordinate and streamline efforts among multiple federal agencies/programs impacting states “on the ground”

State Health Information Exchange (HIE)

Kala Ladenheim, Program Director
Forum for State Health Policy Leadership
HITChampions - http://www.hitchampions.org
National Conference of State Legislatures

September 12, 2006

Collaboration Within and Among States

- Within States
  - Coordination among state health programs
  - Coordination across units of government/public private
- Among States
  - Geographically based collaborations
    - Regional compacts and authorities
  - Issue-driven collaborations
    - Model legislation/contracts, common standards, reciprocity
  - Joint purchasing and contracting
    - Shared capacity and infrastructure building
- Governmental Associations (NCSL, NGA, etc.)
  - Shared policy development and dissemination
    - Best practices and comparative evaluation
  - Differentiate/define state and federal roles

Lessons Learned

- States Vary in Capacity, Resources and Preferences
  - Fiscal, knowledge, market, infrastructure capacity
  - Policy and political preferences
  - Decision structure, government and public-private
- History Matters
  - Experience, sunk costs, relationships
  - Developmental models / stages of adoption
- Laboratories of Democracy
  - Promising practices and options
  - Requires evaluation, information, funding
  - Dissemination through peers and a honest broker
- States Cope with Diverse Federal Requirements
  - Nationwide consensus should yield national policy
  - $$ incentives are powerful

Importance of State-Federal Partnership

- Significant interdependencies between States and Federal government to realize policy, political and market environment for HIE
- Need for States to understand Federal HIT initiatives to align efforts
- Partnership can be synergistic if agendas are coordinated and information is shared
- States are instrumental to developing a nationwide interoperable infrastructure for health information exchange
- AHIC and ONC needs to consider state implications in all recommendations

The Community

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BREAK

Adoption of EHRs: Where Are We, Where Are We Going, How Can We Know?

David Blumenthal, M.D., M.P.P.
Institute for Health Policy, Massachusetts General Hospital/Harvard Medical School

September 12, 2006

Best Estimates of EHR Adoption

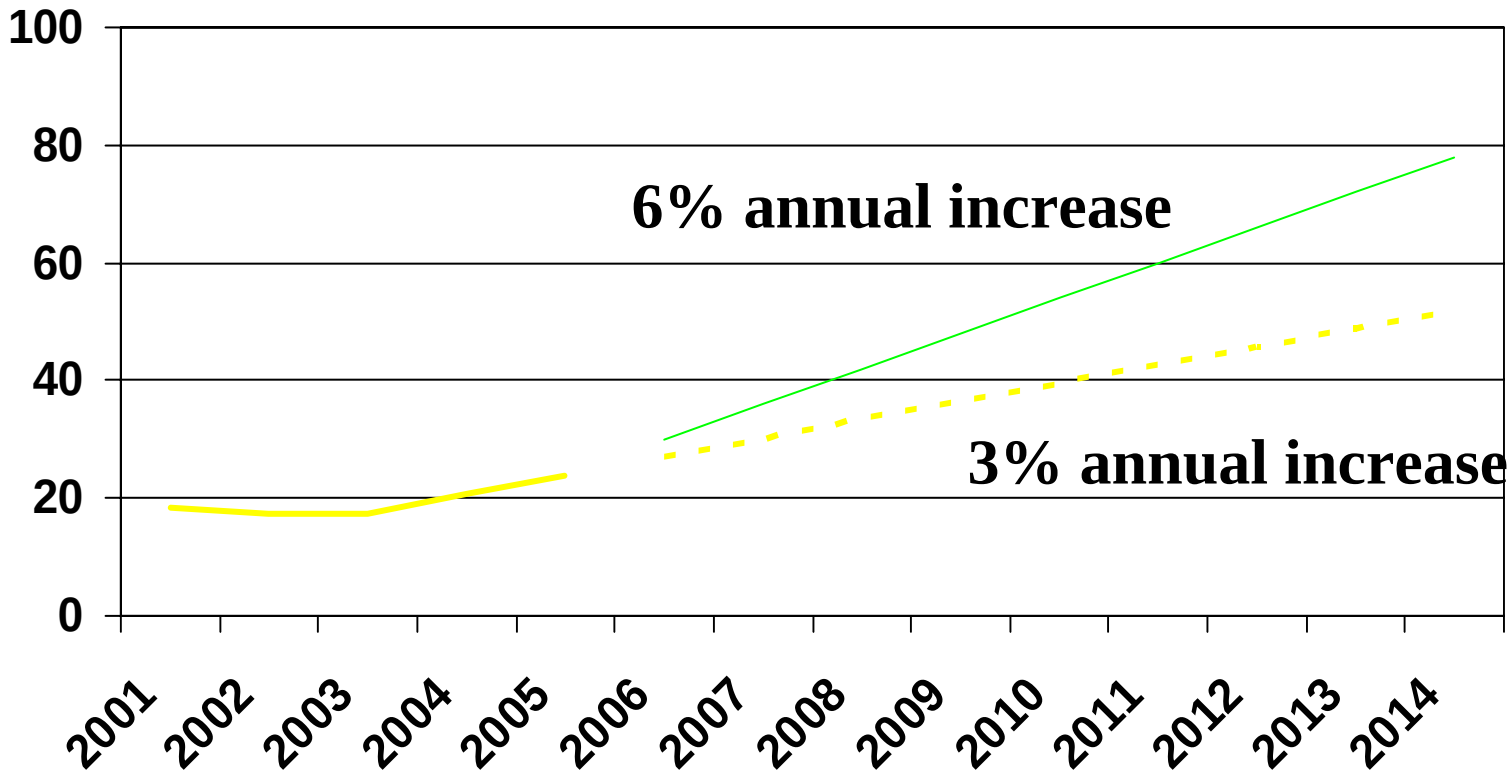
	Range from Medium or High Quality Surveys	Best Estimates Based on High Quality Surveys
EHRs in physician offices	17 to 25%	17%
Solo practitioners	12.9 to 13%	13%
Large physicians offices*	19 to 57%	39%
EHRs in hospitals	16+ to 59% ++	None
CPOE in hospitals	4 to 21 %	5%

* Large is defined as ≥ 20 physicians by one study (with an estimate of 39%) and ≥ 50 physicians (with an estimate of 57%).

+ Estimate from a survey rated “low” in quality of methodology

++ Estimate from a survey quality of content suggested “low” in confidence in the estimate

Projected Diffusion of EHRs Among Office-Based Physicians: 2001-2014



2006-2014 %'s are estimated based on current rate of adoption.

Getting Better Data on EHR Adoption

- Define EHR
  - Institute of Medicine definition laying out 8 key functionalities
  - HIT Adoption Initiative modification
- Define Adoption
  - Acquisition
  - Installation
  - Use
- Design data collection methods
  - Identify goals and objectives of policy
  - Build upon existing federal and private surveys
  - Develop complementary surveys that add to and fill in the gaps of NAMCS, AHA and other existing programs of data collection

Getting Better Data on EHR Value, Barriers and Incentives

- Define measures of value
  - Quality
  - Efficiency
- Compare value and efficiency of care with and without EHRs
- Identify barriers and incentives to adoption
- Include measures of barriers and incentives in regular data collection activities

Tracking Use of Electronic Medical Records

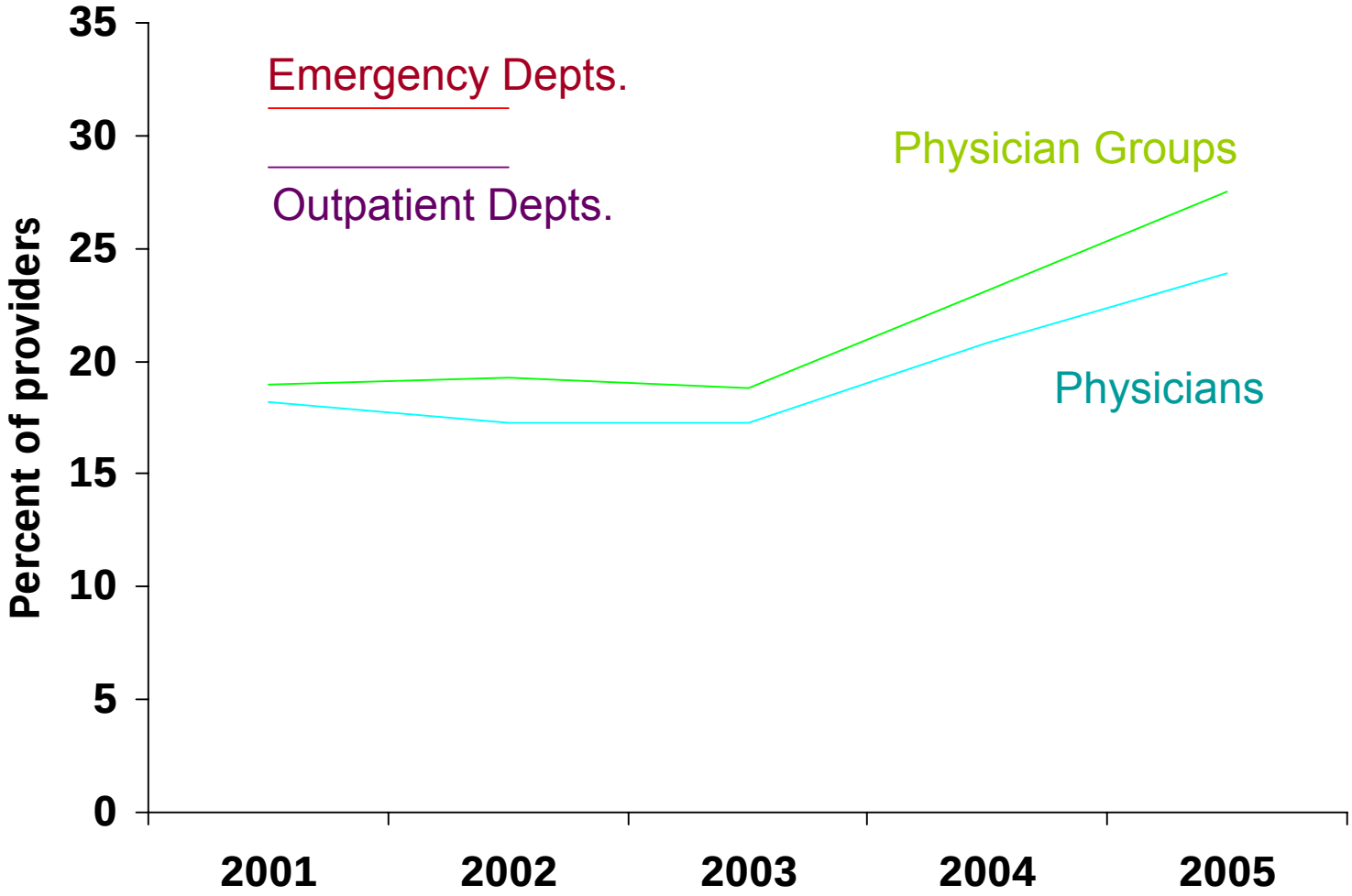
Jane E. Sisk, Ph.D., and Catharine Burt, Ed.D.
National Center for Health Statistics
Centers for Disease Control and Prevention

September 12, 2006

National Ambulatory Medical Care Survey (NAMCS) and National Hospital Ambulatory Medical Care Survey (NHAMCS)

- Annual nationally-representative surveys
  - 3,000 office-based physicians
  - 500 hospitals
- Scope
  - Nonfederal office-based physicians excluding radiologists, anesthesiologists, and pathologists
  - Nonfederal, general and short-stay hospitals with emergency depts. (EDs) or outpatient depts. (OPDs)
- Face-to-face induction interview followed by medical record abstraction: ~30 office visits, ~100 ED visits, ~150 OPD visits
- Response rates: NAMCS ~65%, NHAMCS ~90%

Diffusion of Electronic Medical Records



SOURCE: NAMCS and NHAMCS, 2001-2005

EMR Use, NAMCS, 2005

Practice Characteristic	% Distribution of all Physicians	% Physicians Reporting Full/Partial Use of EMRs
All physicians	100.0	23.9
Size (# of physicians)		
Solo	38.5	16.0
Partner	11.3	20.2
3-5	25.4	25.3
6-10	12.9	33.8
11 or more	9.7	46.1
Ownership		
Physician/physician group	83.3	20.3
HMO	2.9	66.5
Other	13.9	37.1
Region		
Northeast	20.9	14.4
Midwest	21.4	26.9
South	34.9	21.7
West	22.7	33.4

Patients Whose Primary Care Providers Used EMRs

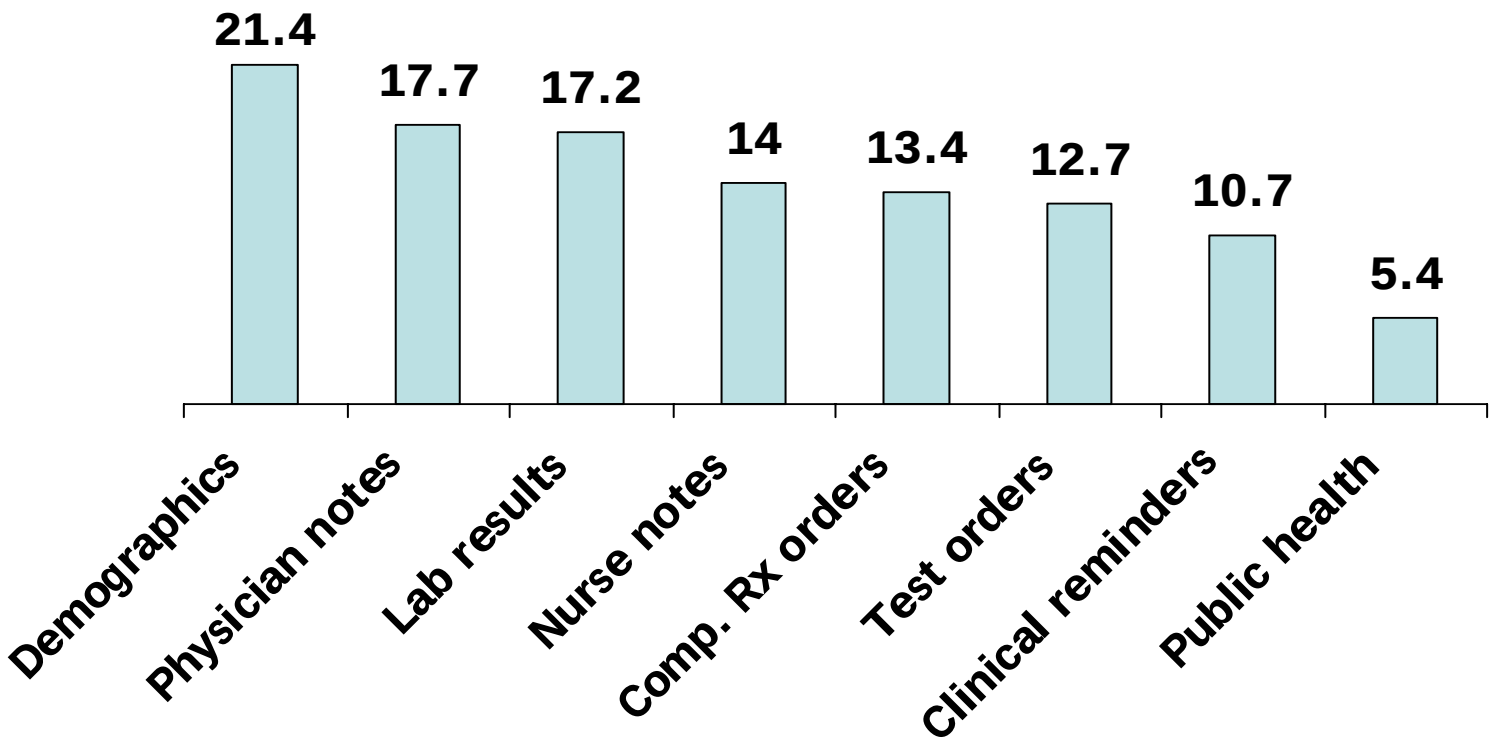
- Of patients who saw primary care providers in 2003 or 2004, 16.6% had physicians who reported using EMRs

  (95% CI: 12.6-21.5)

- This % did not vary by patients' characteristics:

  - Age
  - Gender
  - Race
  - Ethnicity
  - Language ability
  - Region
  - Urban/rural
  - Source of payment
  - Income
  - Education

Percent of Office-Based Physicians Using Selected EMR Features



SOURCE: 2005 National Ambulatory Medical Care Survey

Sustainable High Value Care for All: Searching for Solutions

Michael W. Painter, J.D., M.D.
Senior Program Officer
Robert Wood Johnson Foundation

September 12, 2006

Mr. Romero - 2015

- Health care works the way it's supposed to work.
- Everyone who needs health care can get it when they need it.
- Problems of quality and inequality are fading memories.
- Consumers can trust the safety and accountability of care.
- System is centered fully on taking care of patients – rather than on taking care of itself.

2006 – Health Care Challenges

- Standardized Performance Measurement
- Public Reporting
- Price Information
- Clinical “service” innovation
- Consumer Activation
- HIT implementation
- Inequities

EHR Adoption Critical for High Value Care

- Slow current rates of adoption
- Standardized measures of adoption trajectory
- Standard definition of EHR
- Better picture of EHR adoption by safety net
- Barriers
- Consumer role

Personalized Health Care – Considerations for the American Health Information Community

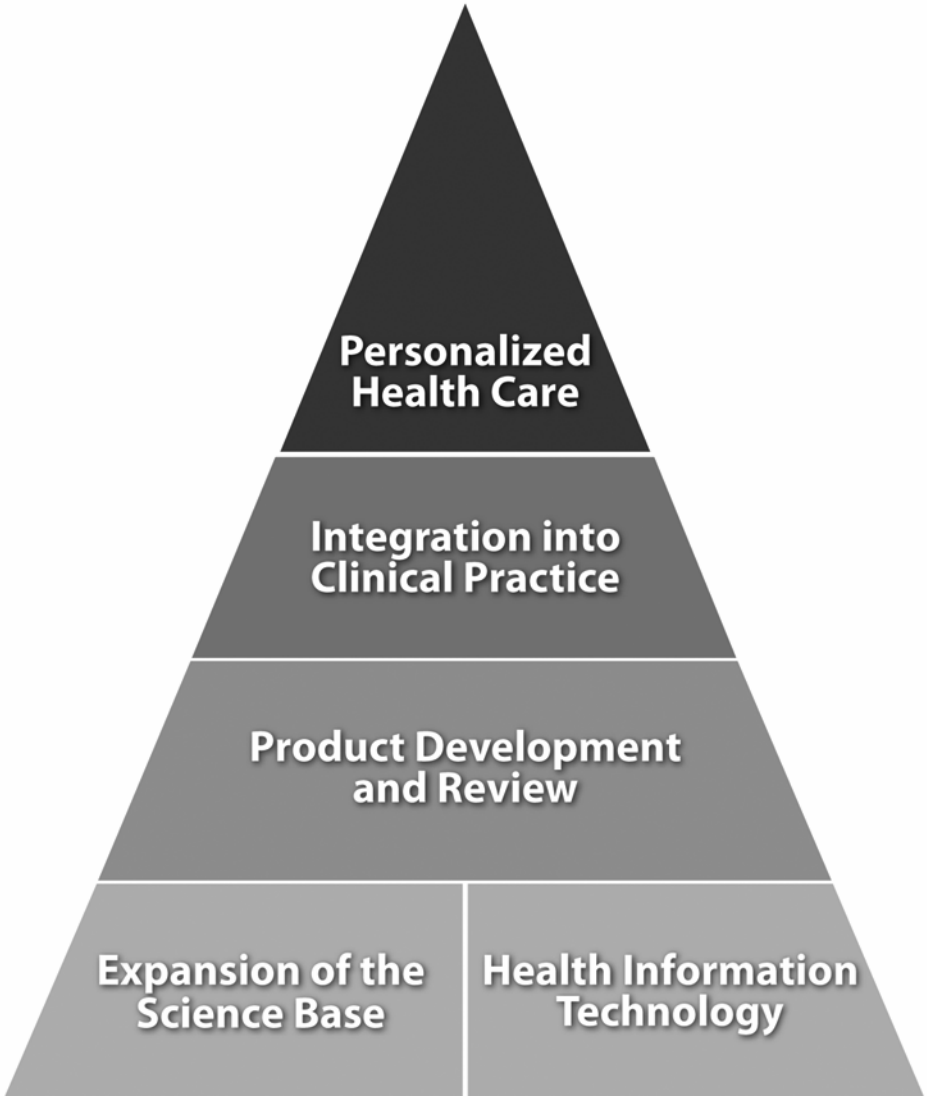
Gregory Downing, Director
Office of Technology and Industrial Relations,
National Institutes of Health

September 12, 2006

Personalized Health Care Initiative

- Rapid advances in science base (e.g., human genome project) in disease processes sets the stage to explain and address individual differences in health states
- Health IT is transforming the health care system by establishing the means for patient-centric care
- The integration of health IT and the genetic information will be transformative in health care practice
- Critical opportunity to anticipate and plan for the future

Building a Base for Personalized Health Care



What are the Emerging Opportunities?

- Many health systems and public resources are beginning to consider incorporation of genetic tests in medical records
- Practical applications of genetic tests are already emerging
  - Identifying risk for disease
  - Confirmatory diagnostic tests
  - Selection of appropriate therapies (pharmacogenomics)
- Technology platform costs for genomic tests are becoming feasible for medical use – and some are already in place
- Multiple standards for the technologies are emerging to facilitate market entry

Gene-based Tests In Medical Management

- Risk factor determination:
  - BRCA1: breast and ovarian cancer
- Treatment selection (pharmacogenomics):
  - HER-2/neu: metastatic breast cancer (Herceptin®)
  - Oncotype Dx®: multi-gene tests for risk of breast cancer recurrence and treatment selection
  - Amplichip®: tests for drug metabolizing enzymes to guide individualized patient dosing regimens of various drugs

A Framework for Building an Interface of HIT, Genomics, and Healthcare

- The genomic framework already exists as DNA is a digital code (A,C,T,G)
- A common, harmonized nomenclature system for genes and disease is already evolving
- Communities already exist that are developing standards for the technology platforms for medical tests but they lack the need of framework to harmonize their efforts
- The stage is being set for integrating genetic test results into medical system and electronic medical records

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PUBLIC INPUT

The Community

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Next Community Meeting

Tuesday, October 31, 2006